Chong S Kim, MD
ENT and Facial Plastic Surgeon

100 Commons Way, Suite 701
Holmdel, NJ 07733
Phone: 732-796-0182
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300 Perrine Rd., Suite 301
Old Bridge, N.J 08857
Phone: 732-727-1355
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Today's Date_____

PATIENT INFORMATION

*Please Print Patient's Complete Legal Name

Patient's Name _____

Address _____

City, State, Zip _____

Patient's E-Mail Address_____ Web Enable YES or NO

Home Tel: ( ) _____-_____ Cell Tel: ( ) _____-_____ Marital Status_____

Birth Date_____ Age_____ Sex_____ Social Security #_____-_____-_____

Referred to Our Office by_____ Phone_____

Primary Care Physician_____Phone_____

Patient's Employer_____Occupation_____

Employer Tel: ( ) _____Employer Address _____

Spouse's Name _____Spouse's Work # _____

Next Of Kin _____ Relationship_____ Phone _____

_____

BILLING INFORMATION

_____

Policy Holder's Name _____ **Date of birth** _____

S.S. #_____

Billing Address (if different from above) _____

Relationship to Patient~

Patient's Height_____ Patient's Weight_____

Flu Vaccine Yes or No, If Yes, date_____

Pneumonia Vaccine Yes or No If yes, date_____

Do you have or have you had:

Diabetes	Y	N
Hypertension	Y	N
Stroke	Y	N
Cancer	Y	N
Ulcers	Y	N
Heart Disease	Y	N
Heart Attack	Y	N
Angina	Y	N
Heart Failure	Y	N
Emphysema	Y	N
Pneumonia	Y	N
TB	Y	N
Arthritis	Y	N
Kidney Disease	Y	N
HIV / AIDS	Y	N
Hepatitis	Y	N
Bleeding Disorder	Y	N
Asthma	Y	N
Thyroid Disease	Y	N

Special History:

Please list current medications:
_____
_____
_____

Please list allergies and type of reactions:
_____
_____
_____

Please list past surgical procedures:
_____
_____
_____

Please list previous diagnostic tests, (pertaining to eyes, nose or throat) i.e., X-RAYS, CT SCANS, Etc.
_____
_____
_____

Do you smoke? Y N
How much? _____
How long? _____

Please list environmental or food allergies:
_____
_____

Pharmacy Name and # _____

Drink Alcohol? Y N
How much? _____
How long? _____

Has anyone in the family suffered from:

Hearing Loss	Y	N
Diabetes	Y	N
Heart Disease	Y	N
Lung Disease	Y	N
Fever with anesthesia	Y	N
Bleeding Disorders	Y	N

Complete Family History:

Are your parents alive?
Mother _____
Father _____

How many siblings do you have?
Brother (s) _____
Sister (s) _____

Are they healthy Y N
If no, Explain
_____

Reason for Appointment: _____

Review of Systems:
(Circle items that apply to you)

General:	Change in appetite / fatigue
Eyes:	Vision changes / dry eyes / excessive tearing / blurring / double vision / cataract
Ears:	Hearing loss / ringing / pain / discharge / dizziness
Nose:	Sinus problem / breathing difficulty / nose bleed / loss of smell
Throat:	Pain / voice change / hoarseness / coughing blood

Heart: Chest pain / shortness of breath upon exertion / shortness of breath at night / palpitation

Lungs: Coughing / wheezing / shortness

Gastrointestinal: Indigestion / heartburn / swallowing difficulty / pain on swallowing / abdominal pain / diarrhea / Constipation / bloody stool

Genitourinary: Difficulty with urination / pain on urination / blood in urine / incontinence

Hematologic: Easy bruising / bleeding tendency / low blood count

Skin: Rash / mole / lump / sore / eczema

Endocrine: Excessive thirst / frequent urination / cold or heat intolerance / weight loss / weight gain

Musculoskeletal: Joint pain or swelling / back pain / arm or leg problems

Neurologic: Numbness / tingling / weakness / fainting / seizure / dizziness / tremor

Psychiatric: Emotional disturbance / depression / drug or alcohol problem

Females Only:
Vaginal Bleeding Y N

Date of last period _____

Are you pregnant Y N

Dr. Kim is also a facial plastic surgeon. Would you be interested in Dr. Kim discussing with you various facial cosmetic and laser services that may be of interest to you? Y N

I authorize the release of any medical information necessary to process my insurance claim

PATIENT'S SIGNATURE _____Date_____
(Parent or Guardian if patient is a minor)

I hereby assign payment of benefit from my insurance company to Chong Kim, PA, but not to exceed the reasonable and customary charges for these services.

INSURED'S SIGNATURE _____Date_____

So that we can better identify your needs, please take a moment to fill out this questionnaire. We greatly appreciate you time.

How good is your hearing? Would you be interested in having your hearing tested? _____

Listening Situations	Hearing Quality					Importance to You		
	Poor				Normal	Not	Somewhat	Very
Television	1	2	3	4	5	1	2	3
Leisure Activities	1	2	3	4	5	1	2	3
Restaurants	1	2	3	4	5	1	2	3
Church	1	2	3	4	5	1	2	3
Meetings/Groups	1	2	3	4	5	1	2	3
Female Voice	1	2	3	4	5	1	2	3
Male Voice	1	2	3	4	5	1	2	3

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CONSENT FOR USE / DISCLOSURE OF HEALTH INFORMATION

Patient's Name:

Patient's date of Birth: **Patient's SSN:**

Notice to Patient:
By signing this form, you grant us consent to use and disclose your protected health care information for the purposes of **treatment**, various activities associated with **payment** and **health care operations**. Our **notice of Privacy Practices** provides more details on our treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights to you have regarding your health care information.

As stated in our **Notice of Privacy Practices**, we reserve the right to change our privacy practices. If we should do so, we will issue a revised Notice. Since revisions may apply to your health care information, you have a right to receive a copy by contacting our Privacy Officer.

You have the right to **revoke** your consent by giving written notice to our **Privacy Officer**. The revocation will not affect actions that were already taken in reliance upon this consent. You should also understand that if you revoke this consent we may decline to treat you.

You are entitled to a copy of this **Consent Form** after you have signed it.

(To be completed by Patient or Patient's Representative)

I, _____, have read the contents of this Consent form and the Notice Privacy Practices. I understand that I am giving you my consent to use and disclose my health care information to carry out treatment, payment activities and health care operations.

Patient's signature or Signature of Patient's representative Date

Printed Name of Patient's Representative Relationship to Patient

Our Privacy Officer can be contacted as follows:

Name of Privacy Officer: Andrew Kim

Practice address: 100 Commons Way, Suite 701
Holmdel, NJ 07733

Phone: 732-796-0182 Fax: 732-796-0186

Financial Policy

Credit Card Payments:
For your convenience, in addition to cash and checks, we accept Visa, MasterCard, Discover, and AMEX. The minimum amount for credit card payment is $60.00 Any amount less than $60.00 there will be a $5.00 fee added to the transaction.

Co-Payments/Co-Insurance/Deductibles:
Your insurance company requires us to collect co-payments, co-insurance and/or deductible at the time of service. Waiver of the patient's financial obligation constitutes fraud under state and federal regulations. Pursuant to these laws, the practice cannot and will not waive, fail to collect, or discount co-payments, co-insurance, deductibles, or other patient financial responsibility. If you are not able to pay your obligation, you may reschedule your appointment or may choose to be billed for a fee of $5.00

Billing Charges:
A charge of $5.00 per billing statement will be assessed for any unpaid co-payments, co-insurance, deductible, and all outstanding balances beyond the first statement.

Non-Covered and Out of Network Services:
Medical services that are considered by your insurance company to be non-covered, out of network, or not medically necessary will be your responsibility.

Appointment Cancellations & No-Show:
We understand that there are times when you must miss an appointment due to an emergency or obligations due to work or family. We require 24 hour notice to cancel office appointments. If you fail to cancel your appointment with us, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. If you fail to give our office 24-hour's notice, you will be charged a $40.00 fee (for regular) or $150 (for procedure).

Surgery Cancellation:
Any patient who fails to arrive for their surgery or cancel surgery two weeks prior to the scheduled appointment date will be charged a fee of $250.00

Delinquent Balance Appointment:
Patients with a delinquent balance are required to make a payment in full for future services. A delinquent account is defined as a patient balance in excess of 120 days if the patient has not made any payments or sought assistance via financial hardship during this time. If such payment is not made, services may be refused.
Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form:

_____

Patient Signature **Date**